

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Noble a prisoner at HMP Holme House on 7 October 2018

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Noble died of multi-organ failure in hospital on 7 October 2018 while a prisoner at HMP Holme House. This was caused by sepsis, which in turn was caused by an infection in his right arm and leg. He was 44 years old. I offer my condolences to his family and friends.

Mr Noble suffered a number of injuries when he fell from a roof before he went to prison. As a result, he had difficulty moving and found it hard to attend to his personal hygiene needs. It appears that he may have suffered further injuries when he fell in his cell before he was moved to the inpatient unit at Holme House.

The clinical reviewer considered that healthcare staff at Holme House did not complete appropriate care plans or sufficiently manage Mr Noble's deteriorating condition. Mr Noble received a poor standard of care at Holme House, which was not equivalent to that which he could have expected to receive in the community.

I am concerned that Holme House was unable to provide all the escort documentation for Mr Noble's hospital visits, which meant that it was not possible to know if he was restrained.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

June 2019

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Summary

Events

1. On 15 September 2018, Mr Paul Noble was sent to HMP Durham. At an initial reception screen, nurses noted that he had a history of opioid dependence and had difficulty walking due to injuries that he had sustained before he arrived in prison.
2. On 19 September, a prison GP sent Mr Noble to hospital with a suspected broken left wrist. An X-ray confirmed a fracture and he returned to prison with his left arm in a plaster cast.
3. On 24 September, Mr Noble moved to HMP Holme House. At an initial reception screen, a nurse noted that he had several injuries and reported difficulty with self-care. Prison staff allocated Mr Noble a double cell in a residential houseblock and his cellmate told us that one night, Mr Noble fell and was incontinent of faeces while trying to get to the toilet.
4. On 27 September, a healthcare assistant found Mr Noble in his cell, incontinent of faeces, and moved him to the inpatient unit for social care support.
5. At 7.45am on 29 September, a nurse contacted a custodial manager (CM) and asked for Mr Noble to be escorted to hospital as he was concerned that Mr Noble had a swollen right leg and had possibly fractured his right arm. The CM later told a nurse that they did not have enough staff for an escort as they had to prioritise another prisoner. Mr Noble remained in prison that day.
6. On 30 September, an officer asked a nurse if Mr Noble still needed to be escorted to hospital. After examining him, the nurse sent him to hospital. X-rays confirmed that Mr Noble's arm and leg were not fractured and he returned to prison with a leg splint.
7. Mr Noble called out in pain overnight on 1-2 October. Healthcare staff gave him paracetamol and ibuprofen.
8. At around 8.40am, on 2 October, a nurse reviewed Mr Noble and noticed that his right arm and fingers were very swollen. A prison GP saw Mr Noble and sent him to hospital by ambulance. Mr Noble's condition deteriorated rapidly and he died in hospital on 7 October.
9. The post-mortem report concluded that Mr Noble died of multi-organ failure caused by sepsis (when the body's response to infection causes damage to its own tissues and organs), which in turn was caused by an infection in his right arm and leg.

Findings

10. Healthcare staff at Durham should have conducted a secondary health screen for Mr Noble, particularly as he had a number of injuries.
11. Mr Noble arrived at Holme House with a fractured left arm. It appears that he may have suffered injuries to his right arm when he fell in his cell in a residential

houseblock one night before he was moved to the prison's inpatient unit. A more comprehensive reception assessment at Holme House might have resulted in Mr Noble being more appropriately located from the outset.

12. We are concerned that healthcare staff did not sufficiently monitor or manage Mr Noble's deteriorating condition. We agree with the clinical reviewer that the care that Mr Noble received in Holme House was not equivalent to that which he could have expected in the community.
13. We are satisfied that it was appropriate in the circumstances for prison staff to have prioritised a hospital escort on 29 September for a prisoner assessed to have more urgent health needs.
14. We are satisfied that staff did not use restraints when Mr Noble was taken to hospital on 2 October. However, we are concerned that Holme House was unable to locate the escort paperwork for 30 September.

Recommendations

- The Head of Healthcare at HMP Durham should ensure that healthcare staff offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.
- The Head of Healthcare at Holme House should ensure that healthcare staff:
 - consider referring newly arrived prisoners to the prison's inpatient unit if they have health issues which affect their ability to care for themselves;
 - implement appropriate care plans with stated aims, planned interventions and monitoring;
 - know how to detect and manage early warning signs of deterioration in prisoners, including sepsis; and
 - maintain accurate and comprehensive medical records.
- The Governor of HMP Holme House should ensure that all relevant escort documentation is completed before a prisoner leaves prison and is stored securely.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact him/her. One prisoner responded.
16. The investigator obtained copies of relevant extracts from Mr Noble's prison and medical records.
17. The investigator interviewed six members of staff and one prisoner at Holme House on 9 November.
18. NHS England commissioned a clinical reviewer to review Mr Noble's clinical care at the prison. The clinical reviewer attended joint interviews with the investigator on 9 November and conducted five telephone interviews between 9 November and 14 January 2019.
19. We informed HM Coroner for Teesside of the investigation. She gave us the result of the post-mortem examination. We have sent the Coroner a copy of this report.
20. The investigator contacted Mr Noble's mother to explain the investigation and to ask if she had any matters that she wanted the investigation to consider. She wanted to know about the care Mr Noble received at HMP Durham and why staff did not send him to hospital when he reported falling from a roof. We have answered her questions in this report.
21. Mr Noble's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS noted that there is no evidence to confirm what caused Mr Noble's right arm injury and when it occurred. Their action plan is annexed to this report.

Background Information

HMP Durham

23. HMP Durham is a reception prison, serving the courts within its catchment area of Carlisle to North Yorkshire. It holds approximately 1,000 men. G4S provides primary healthcare service at the prison. There is a 24-hour healthcare inpatient unit with six beds.

HMP Holme House

24. Holme House is a Category C training prison holding over 1,200 men. Until May 2017, it was a Category B local prison, holding men on remand or who had recently been convicted by courts in the local area. G4S provides nursing and administrative services at the prison and Spectrum CIC (Community Interest Company) provides GP and pharmacy services. There is a 24-hour healthcare inpatient unit with 16 beds.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Durham was in September 2018. Inspectors reported that although most prisoners stayed for very short periods of time, they had good access to health services. Inspectors found that primary care staffing levels were good and that medical emergencies were well managed.
26. The most recent inspection of HMP Holme House was in July 2017. Inspectors reported that the healthcare interactions that they observed between staff and prisoners were very good but they noted that chronic staff shortages in the primary care nursing team had affected service delivery.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently.
28. In its latest report for the year to October 2018, the IMB at Durham reported that the recruitment of primary care nurses continued to be a major issue and waiting times for non-urgent GP appointments had increased from two to three weeks.
29. In its latest report for the year to December 2017, the IMB at Holme House reported that plans were in place to restructure the delivery of primary care but that the plans had been compromised by significant staff shortages, including difficulties in recruiting and retaining healthcare staff.

Previous deaths at HMP Holme House

30. Mr Noble was the fourteenth prisoner to die at Holme House since October 2015. Of the previous deaths, nine were from natural causes, two were self-inflicted and one is awaiting classification. There have been two deaths since, one from natural causes and one awaiting classification. We have previously raised a concern about healthcare monitoring and support.

Key Events

31. In December 2011, Mr Paul Noble was sentenced to eight years in prison for grievous bodily harm. On 2 December 2016, he was released on licence from HMP Northumberland but was recalled to HMP Holme House four days later for breaching his licence conditions. On 19 March 2018, Mr Noble was released on licence from Holme House but was recalled to HMP Durham on 15 September, again for breaching his licence conditions.
32. At an initial reception screen, a nurse noted that Mr Noble had a history of opioid dependence, for which he was prescribed methadone. Another nurse recorded that he had difficulty walking due to injuries he had suffered when he fell off a roof while trying to evade police. She also noted that he used a crutch, which he said that prison staff gave him. Shortly afterwards, a prison GP examined Mr Noble and noticed that he limped and that his left thigh was tender. He prescribed ibuprofen and paracetamol and recorded that Mr Noble would require a GP review in one week to assess his progress.
33. On 17 September, a prison GP who specialises in substance misuse reviewed Mr Noble and prescribed methadone. He noted that Mr Noble did not have any withdrawal concerns but reported a wrist injury and pain when walking. While it is not clear if he referred Mr Noble to the primary healthcare team, medical records show Mr Noble failed to attend a GP appointment the next day.
34. On 19 September, a prison GP reviewed Mr Noble. He suspected that he had a broken wrist and sent him to the University Hospital of North Durham. Hospital staff assessed that Mr Noble had fractured his radius bone (which is close to the wrist). He returned to Durham later that day, with his left arm in a plaster cast. There is no record that healthcare staff reviewed him or conducted a secondary health screen.
35. On 24 September, a nurse reviewed Mr Noble's transfer paperwork and recorded that he was fit to move prisons. Later that day, he moved to HMP Holme House. At an initial reception screen, a nurse noted that Mr Noble had a swollen right hand, a fractured left wrist and was unable to perform personal care. He requested an urgent GP review and a social care assessment. Prison staff assigned Mr Noble to a shared cell on a standard houseblock and later that day, a healthcare assistant conducted a secondary health screen.
36. At interview, Mr Noble's cellmate told the investigator that Mr Noble had a limp and his arm was in a plaster cast. He said that they only shared a cell for a brief period, and that one night, Mr Noble fell over and was incontinent of faeces while trying to get to the toilet. He said that he pressed the emergency cell bell and alerted a member of prison staff but was told to wait. There is no record of this in the houseblock observation log.
37. On 27 September, a healthcare assistant went to Mr Noble's houseblock to help a nurse to issue methadone. An officer informed her that Mr Noble could not move due to his injuries and she went to his cell, where she found him lying in bed, incontinent of faeces. She took his clinical observations, which were normal. She completed a National Early Warning Score assessment (NEWS – a scoring

system to assess clinical deterioration in patients) and based on his observations, she scored him '0' (low clinical risk).

38. The healthcare assistant transferred Mr Noble to the prison's inpatient unit for social care support and a nurse saw him on admission. She noted that Mr Noble presented as under the influence of an illicit substance and, therefore, declined to issue him with methadone. That evening, a mental health nurse took Mr Noble's clinical observations and recorded a NEWS score of '0'. There is no record that a physical examination or a social care assessment was conducted for Mr Noble.
39. On 28 September, a nurse noted that Mr Noble had used his cell bell throughout the night to request pain relief for abdominal pain. She gave him paracetamol and ibuprofen twice and recorded that he settled afterwards. At interview, she told the clinical reviewer that she did not consider that Mr Noble needed a pain review as she believed that his pain would subside once he had taken methadone. Later that morning, a nurse assisted Mr Noble with his personal hygiene needs and noticed that he did not have a social care plan. She noted that she would ask staff to help her formulate a care plan. There is no record that a care plan was developed.
40. At 6.09am on 29 September, Mr Noble told a nurse that he was incontinent of faeces and she helped him with his care needs. At 7.45am, another nurse contacted a Custodial Manager (CM) and asked for a hospital escort for Mr Noble as a nurse was concerned that he had a swollen right leg and a possible fracture to his right arm. The CM liaised with the Duty Governor, but at 4.36pm, he told the nurse that they did not have enough officers to escort Mr Noble to hospital. He said that they had to prioritise another prisoner with more urgent health needs but would try to take Mr Noble in the morning.
41. At 5.07am on 30 September, a nurse recorded that Mr Noble had passed a large amount of black faeces and had difficulty moving. There is no record that she took his clinical observations, considered seeking advice from a senior member of staff or followed up his hospital transfer. At 9.19am, an officer asked another nurse if Mr Noble still needed hospital treatment and the nurse saw Mr Noble for a review. He noticed that his right leg and right hand were very swollen and suspected sepsis (when the body's response to infection causes damage to its own tissues and organs) or deep vein thrombosis (DVT - a blood clot in one or more of the body's deep veins). He sent Mr Noble to the Hospital.
42. Hospital records show that Mr Noble said that he had fallen off a top bunk bed and injured his right hand and knee around four to five days earlier. X-rays confirmed that he did not have a fracture. That afternoon, a healthcare assistant spoke to a hospital nurse. She noted that Mr Noble was returning to prison with a leg splint and would need his right arm elevated at night. At interview, a nurse told us that Holme House did not have the equipment to elevate limbs.
43. On 1 October, a nurse saw Mr Noble for a review and noted that he had pain in his arms and legs. She gave him paracetamol and ibuprofen and recorded that he had a dry mouth and cracked lips (a sign of dehydration). There is no record that she considered a care plan to monitor his condition.

44. At 6.25am on 2 October, a nurse recorded that Mr Noble had called out in pain through the night. She gave him paracetamol and ibuprofen and noted that it had negligible effect. There is no record that she considered referring Mr Noble to a GP or that she undertook a NEWS assessment.
45. At around 8.40am, a nurse reviewed Mr Noble and noticed that his right arm and fingers were very swollen. She requested a GP review and, based on his observations, recorded a NEWS score of '1' (low clinical risk). There is no record that she considered a sepsis risk assessment. At 11.35am, a prison GP examined Mr Noble and found that his right calf was 3cm larger than his left calf. He noted that Mr Noble had swelling in his left leg and, suspecting DVT, sent him by ambulance to the hospital. Two officers went with him and did not use restraints.
46. On 3 October, a nurse contacted the hospital for an update and was told that Mr Noble had been admitted to the Intensive Treatment Unit. Hospital staff initially diagnosed and treated Mr Noble for septic arthritis (a joint infection) and an acute kidney injury (where the kidneys suddenly stop working properly as the result of another illness). Prison healthcare staff kept in frequent contact with the hospital for updates about his condition.
47. Mr Noble's condition continued to deteriorate rapidly and he died in hospital at 8.34pm on 7 October.

Contact with Mr Noble's family

48. At 6.00am on 3 October, the prison appointed a family liaison officer. At 8.15am, the prison family liaison officer phoned Mr Noble's mother, his named next of kin, but she did not answer. She visited Mr Noble in hospital and, at 11.20am, phoned his sister to tell her of his condition.
49. At 8.45am on 7 October, the prison family liaison officer contacted the hospital and a nurse told her that Mr Noble had deteriorated. She phoned Mr Noble's mother and met her at the hospital to provide support. Mr Noble's mother and sister were present when he died.
50. At 2.00pm the next day, the prison family liaison officer and an officer met Mr Noble's family at his sister's address and offered their support. The prison family liaison officer provided ongoing support to Mr Noble's sister and attended his funeral on 23 October with a prison manager. The prison contributed towards the cost of the funeral, in line with national policy.

Support for prisoners and staff

51. After Mr Noble's death, a CM debriefed the staff present at the hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support.
52. The prison posted notices informing other prisoners of Mr Noble's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Noble's death.

Post-mortem report

53. The post-mortem report found that Mr Noble died of multi-organ failure due to sepsis caused by an infection in the right forearm and right calf. Mr Noble was also found to have cirrhosis of the liver which contributed to but did not cause his death.

Findings

Clinical care

54. The clinical reviewer concluded that the clinical care that Mr Noble received in prison was not equivalent to that which he could have expected to receive in the community.
55. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that newly arrived prisoners should be offered a general health assessment in the week after first reception. This assessment is expected to be equivalent to a primary care assessment when registering with a new GP in the community. Although healthcare staff at Durham saw Mr Noble for an initial reception screen and a GP appropriately sent him to hospital on 19 September, healthcare staff should have completed a secondary health screen for him. This was particularly important as Mr Noble arrived at prison reporting a number of injuries from falling off a roof and he had a history of substance misuse.
56. When Mr Noble arrived at Holme House, staff requested a social care assessment and an urgent GP appointment. However, there is no record that these took place. We are concerned that despite Mr Noble's poor health, healthcare staff did not consider whether to refer him directly from reception to the inpatient unit. Had they done so, Mr Noble might have received more prompt support for his care needs. With hindsight, he might also not have sustained the additional right-sided injuries which appear to have occurred while he was located on a residential houseblock.
57. The clinical reviewer considered that healthcare staff should have created care plans to assist Mr Noble with his personal care and to monitor his condition. At interview, the Deputy Head of Healthcare told us that care plans are available on the electronic medical system and staff can complete them according to individual need. She said that Mr Noble had care plans, but we found no evidence of this.
58. The clinical reviewer found that healthcare staff failed to manage Mr Noble's deteriorating condition appropriately after he was moved to the inpatient unit. She noted that staff failed to complete a social care assessment, only made sporadic use of a NEWS score and missed at least one opportunity to escalate Mr Noble's condition to a doctor or a senior member of medical staff. We consider that staff should have managed Mr Noble's care more proactively. We are particularly concerned that an officer had to ask healthcare staff if Mr Noble still needed to go to hospital on 30 September.
59. Mr Noble reported significant pain to healthcare staff after he returned to prison. The clinical reviewer noted that staff should have considered undertaking a pain review and used a NEWS score to monitor his condition. On 2 October, a nurse recorded a NEWS score and appropriately escalated her concerns to GP. However, the clinical reviewer considered that considering Mr Noble's presentation, and despite his normal NEWS score, which can be used to indicate sepsis, staff should have conducted a sepsis risk assessment. We make the following recommendations:

The Head of Healthcare at HMP Durham should ensure that healthcare staff offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.

The Head of Healthcare at HMP Holme House should ensure that healthcare staff:

- **consider referring newly arrived prisoners to the prison's inpatient unit if they have health issues which affect their ability to care for themselves;**
 - **implement appropriate care plans with stated aims, interventions and monitoring;**
 - **know how to detect and manage early warning signs of deterioration in prisoners, including sepsis; and**
 - **maintain accurate and comprehensive medical records.**
60. When healthcare staff requested a hospital escort for Mr Noble on 29 September, a CM liaised with the Duty Governor. The Duty Governor told the investigator that healthcare staff wanted to send two prisoners to hospital but, as it was a weekend, he did not have enough staff available to facilitate two escorts. He said that healthcare staff did not consider either prisoner a medical emergency and if they had, he would have ensured that the escorts took place regardless of their impact. He said that he could facilitate one escort and decided to send the other prisoner to hospital, as healthcare staff assessed his condition as more urgent than Mr Noble's. A nurse told us that he informed prison staff that Mr Noble's condition was urgent and that he needed to go to hospital. He said he escalated his concerns to the Deputy Head of Healthcare, who told us that the CM told her that Mr Noble would be going to hospital that afternoon.
61. We are satisfied that prison staff appropriately took account of healthcare concerns about Mr Noble, in conjunction with those of another prisoner, when deciding on whether to facilitate an escort. There is no record to indicate that Mr Noble required immediate emergency medical intervention and in the circumstances it was reasonable that officers facilitated his escort the following morning.

Restraints, security and escorts

62. When prisoners travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as a prisoner's health and mobility.
63. We are satisfied that when Mr Noble went to hospital on 2 October, a prison manager authorised two officers to escort him but appropriately did not restrain him due to his fractured wrist and swollen right hand.

64. However, despite our requests, Holme House could not locate the escort paperwork to show whether staff used restraints when Mr Noble went to hospital on 30 September. A prison manager told the investigator that she liaised with the prison's security department and was told that as it was a Sunday, the paperwork might not have been completed.
65. In the absence of documentation, we cannot know what happened and therefore make the following recommendation:

The Governor of HMP Holme House should ensure that all the relevant escort documentation is completed before a prisoner leaving the prison and stored securely.

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